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MATERNAL CHILD HEALTH, FAMILY PLANNING AND REPRODUCTIVE HEALTH STRATEGIC APPROACH

DRAFT FOR DISCUSSION – NOVEMBER 2008

ACRONYMS

ANC	Antenatal Care
BCC	Behavior Change Communication
CHEW	Community Health Extension Workers
COMPASS	Community Participation for Action in the Social Sector
CPS	Country Partnership Strategy
DfID	Department for International Development (UK)
DOD	Department of Defense
EEDS	Economic Empowerment Development Strategy
EmONC	Emergency Obstetric and Newborn Care
ENHANSE	Enabling HIV/AIDS and TB and the Social Section Environment
FP/RH	Family Planning, Reproductive Health
GHAIN	Global HIV/AIDS Initiative Nigeria
HIV/AIDS	Human Immuno-deficiency Virus
IMNCH	Integrated Maternal, Newborn and Child Health Strategy
IEC	Information, Education and Communications
ITN	Insecticide Treated Nets
IUD	Intrauterine Device
IP	Implementing Partner
IPD	Immunization-Plus Day
LGA	Local Government Authority
LAM	Lactational Amenorrhoea Method
MCH	Maternal Child Health
MCH/FP/RH	Maternal Child Health, Family Planning and Reproductive Health
MDG	Millennium Development Goals
MNCH	Maternal, Newborn, Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Non-Governmental Organization
NPHCDA	National Primary Health Care Development Agency
NEEDS	National Economic Empowerment Development Strategy
ORT	Oral Rehydration Therapy
PEPFAR	President's Emergency Plan for AIDS Response
PHC	Primary Health Care
PMTCT	Preventing Mother to Child Transmission
PRIME	Partnership to Reinforce Immunization Efficiency
PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
PSP-One	Private Sector Partnerships One
SDM	Standard Days Method
SPHCDA	State Primary Health Care Development Agency
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/Nigeria	United States Agency for International Development in Nigeria
WB	World Bank
WHO	World Health Organization

Maternal Child Health, Family Planning and Reproductive Health Strategic Approach
USAID/Nigeria
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Background and Context

Strengthening the health sector and improving health indicators are among the most important development issues facing Nigeria. About one million children die each year before their fifth birthday, and infant and child mortality rates are extremely high, even when compared to other sub-Saharan countries. Maternal mortality rates are among the highest in the world, particularly in the northern states, and completed fertility remains over 7 in the northern states, where childbearing starts very early and births are very closely spaced. For Africa, and potentially for the world, the Millennium Development Goals (MDGs) in maternal and child health cannot be reached without major improvements in the health status of Nigeria's women and children.

A positive note is that the Government of Nigeria and the international partners in Nigeria are coming together to develop coordinated strategies, policies and plans to address these urgent public health issues. On the donor side, the Country Partnership Strategy (CPS), initially developed by the World Bank and Department for International Development (DfID), and now involving a number of other donors including the United States (US), provides a systematic framework (at the macro level) for coordinated development assistance to Nigeria, including in health. Government, with input from partners, has also developed a "National Economic and Empowerment Development Strategy" (NEEDS), the equivalent of a Poverty Reduction Strategy; several states have also developed or are developing state-level Economic and Empowerment Development Strategies (EEDSs).

In the area of maternal and child health, the Federal Government and partners have recently developed an "Integrated Maternal, Newborn, and Child Health (IMNCH) Strategy," which lays out a collaborative strategic approach to accelerating progress in reducing child and maternal mortality (including the role of family planning). This IMNCH Strategy has been approved by the National Council for Health, and plans are being made to implement it through advocacy and analytical support, initially in twelve states. Donors have worked closely with the Government in all stages of this process. In addition, many donor and international organization partners (UNICEF, WHO) are themselves entering the process of developing strategies and activities for a new programming cycle, providing excellent opportunities for coordinated planning. Overall, the environment is highly positive for United States Agency for International Development's (USAID) strategy development in coordination with government and other partners.

USAID has a long history of activities in the health sector, including maternal child health (MCH), family planning and reproductive health, malaria, tuberculosis, and HIV/AIDS. In MCH/FP/RH, these activities have included support for development of policies, planning, norms, and standards at the federal, state, and local levels; building of key capacities; and targeted strengthening of key system elements (such as logistics at the distal end of the delivery system). USAID has especially been engaged in developing approaches to improve delivery of key MCH/FP/RH services at the operational (primary and first referral) levels of the public health system; in demonstrating how community mobilization can make major contributions to increasing healthy behaviors and demand for health services as well as to improving those services themselves; and in applying social marketing and other private sector approaches. While these activities have generally been at limited scale, they have provided important opportunities to learn concretely what can be done at the community and delivery levels of the health system to improve health outcomes.

Over the past year, USAID/Nigeria has conducted a number of reviews, assessments and evaluations to document lessons learned and provide guidance for the new strategy. A review of the state of family planning, an evaluation of the Community Participation for Action in the Social Sector (COMPASS), Enabling HIV/AIDS and TB and the Social Sector Environment (ENHANSE), and ACCESS activities, and a review of immunization activities have all been conducted. The strategy development team has reviewed these documents, and has participated in discussions of their recommendations, has met with other donors and Government officials, has consulted with USAID Mission staff, and has visited Kano to meet with State health officials and observe program activities. The findings of all of these data collection activities point towards greater coordination, greater focus technically and geographically, and strategic integration of key program areas and resources.

Within USAID there is an opportunity for achieving synergy and impact through greater integration of FP/RH and MNCH activities, including malaria and routine immunization programs. These activities, in turn, should be coordinated with HIV/AIDS, governance, and water and sanitation activities. In sum, the time is right for greater coordination and synchronizations within USAID itself, with other partners, and with the Government of Nigeria (GON) on the central and state levels.

The recommendations in the following sections reflect the strategy team's attempt to take greatest possible advantage of all these experiences and opportunities, within a vision of increasing the effectiveness, impact, and influence of USAID/Nigeria's MCH/FP/RH assistance during the period 2009-2016. They are also consistent with the USG's (and USAID's) broader commitment to the Paris Declaration on improving aid effectiveness and the Millennium Development Goals, and USAID's intention to increase the application of private sector resources to development in the interest of countries and their people.

Recommended Elements of USAID's 2009-2016 Strategic Approach

1. Plan and carry out MCH/FP/RH assistance and support within an overarching framework

To assure coherence among implementing partners and activities in different program areas and at different levels of the health system, USAID should develop its assistance within an overall programmatic and policy framework (Figure 1) that identifies the needs and opportunities for donor inputs at different levels along with the potential comparative advantages of its own resources and types of assistance against those of other partners.

Ideally, such a framework should represent consensus among USAID, other donor partners, and government at relevant levels. Opportunities to develop such a consensus framework now exist in the plan to develop a national strategic plan for health, as well as the intention of some states (e.g., Kano) to develop their own health strategic plans in consultation with partners.

2. Maximize collaboration with other major donors and partners

Donor coordination is absolutely essential in a context where Nigeria's resources are vast in relation to the combined resources of donors, where states are the size of countries, and where programs are highly complex. There is a very positive donor environment at the present time, with partners meeting regularly to assist the GON in developing strategies, setting policies and planning implementation of programs in a selected set of states. Among donors, key benefits of this improved coordination include more effective support of government programs; greater leveraging of resources; greater influence through having "one voice;" and complementarities in terms of expertise, inputs, mechanisms, and geographic areas. Donor

coordination also facilitates and creates the conditions for sharing of lessons learned and broad application of successful approaches.

The donor community in Nigeria in 2008 has taken many steps to improving coordination among themselves and to working in partnership with the Government more strategically. The have moved from simply sharing information about programs to coordination of the donors around a Government of Nigeria strategy. An example is the nationally approved "Integrated Maternal, Newborn and Child Health Strategy (IMNCH) Strategy," which donors and other partners assisted in preparing and for which they are preparing a roll-out plan in collaboration with the Government. Another key framework for cooperation, the "Country Partnership Strategy" (CPS) was initially prepared by the World Bank and DfID, but is now being supported by a range of other donors including USAID. The comprehensiveness of the analysis and the strategic directions outlined in the CPS provide the donor community with a united front on which discussions with the government can be based.

USAID should continue to work closely with partners involved in the Country Partnership Strategy and with the IMNCH process to assure strategic consistency and maximum impact of the various areas of expertise and programming strengths that USAID and its implementing partners can provide on the national and the state levels.

3. Focus the program

a. Geographically –

Nigeria is Africa's most populous country, with a population of approximately 140 million people and a growth rate of 2.8 percent. There are 36 states and 774 Local Government Authorities (LGAs). Given this scale, and a very wide range of cultures, social structures, health indicators and availability of health services, focus is imperative. USAID's 2004-2009 strategic plan emphasized an integrated, strategic approach to health sector interventions. However, for political, historical, and other reasons, USAID's MCH/FP/RH activities have been implemented in six states and a large number of LGAs. Sometimes one element of program (e.g., maternal health care improvement) might be implemented in some states or areas, while other elements (e.g., immunization) would be carried out in others. In other cases, multiple program elements might be carried out in shared or overlapping areas, but by different implementing partners (IPs) with somewhat different approaches to similar service delivery problems.

The 2009-2016 strategy should focus USAID's assistance further, by identifying a selected set of high-impact interventions and by assuring IP and donor coordination, in order to achieve maximum impact. The following criteria for selection of focus states should be considered:

- levels of need (health indicators)
- commitment of the state to health issues and good governance
- size of the population; ratio of USAID MCH/FP/RH resources to population
- planned or ongoing presence of other USAID programs with which MCH/FP/RH can interact in a win-win investment approach
- other donor presence and potential for leveraging
- requests by the state for USAID partnership
- private sector opportunities
- previous USAID investment and results, and
- potential regional and zonal influence.

Given available resources and need for adequate "mass" in a given state to have influence and impact, it was recommended that two states be selected as the focus for USAID's 2009-2016 MCH/FP/RH program and policy activities.

It is recommended that the portion of the mission's MCH/FP/RH program assistance dealing with strengthening public sector services be focused exclusively in two states. Private sector activities may extend beyond the two focus states, but should be implemented to deliver maximum possible coverage and saturation in the two chosen focus states.

b. Core package of interventions -

The Nigerian health system is weak and the needs are great. Indicators of maternal and child health are exceptionally poor, particularly in the north. The challenge is to identify a very selective set of interventions that, taken as a package, have the potential to:

- reduce some of the major causes of maternal and child morbidity and mortality
- are feasible to consider delivering with reasonable and replicable inputs, and
- help build key elements of a functioning health system (both public and private sector), so that other interventions can later be introduced on the "platform" that this core package helps establish.

While the final determination will need to be made with focus state and local governments and with partners, the interventions recommended are:

Family planning: With total fertility rate (TFR) over seven in the north, and averaging around 5.5 nationally, early and closely-spaced births contribute to poor maternal, infant and child health indicators, as well as straining family resources and exacerbating other health problems. Assessments and evaluations have highlighted recent increases in the acceptability of family planning and the success of a number of community-based approaches. Any family planning program should include an adequate range of methods to assure that women can choose an appropriate method for their situation, although weaker systems like Nigeria's may not be able to provide every method. The minimum choice of methods which should be made available in the Nigerian context at the current stage of development of the program includes pills, condoms, injectables, lactational Amenorrhoea Method (LAM), Standard Days Method (SDM) and intrauterine Devices (IUDs). All of these methods, with the possible exception of IUDs, can be made available by trained community level workers (either at a facility, or by outreach into the community). In addition to method provision, there is a need for behavior change communications (BCC), including both mass media and interpersonal approaches, to promote "healthy timing and spacing" messages, that may include the risk factors associated with high parity and the age of the mother, both too young and too old. Efforts should be made to reach male partners as involving men has shown to increase use of reproductive health services, including contraception, maternal and child health care. Other message may be developed as appropriate.

"Antenatal care+": In a population where demand for preventive services is relatively weak, it is significant that a majority of women make at least one antenatal care visit, and a significant number of women make two or more visits. This provides a window of opportunity for provision of a package of high-impact interventions: tetanus toxoid (TT), intermittent prevention treatment (IPT), and insecticide treated nets (ITNs) for malaria prevention, iron supplementation and nutritional counseling, counseling on exclusive breast feeding, LAM, and transition to other family planning methods. These antenatal visits should be used to counsel mothers and provide reminder materials on danger signs of pregnancy, delivery, and the post-partum and newborn period, on planning for use of referral facilities in case of these complications, and on basic newborn care. They should also be used to identify other MCH needs, such as routine immunizations or counseling on the use of oral rehydration therapy (ORT) for diarrhea. The use of a systematic screening tool such as that developed by the Population Council at the antenatal

visit could assist in identification of unmet needs for maternal, infant and child health interventions, and filling these gaps. Of course, a *sine qua non* for the applicability of this tool is the availability of the necessary services at site (or less desirably, by referral) to fill the identified needs.

Recognition of Complicated Pregnancy and Emergency Obstetric and Newborn Care (EmONC): During the next five years, USAID's efforts need to help develop and support a transitional approach with four basic components:

- increasing availability of skilled attendance at birth at home, primary health care (PHC), and referral level facilities
- increasing utilization of these skilled birth attendants and facilities for delivery
- assuring recognition of danger signs and complications of pregnancy and delivery, and removing barriers to timely movement of women experiencing these complications to appropriate facilities (usually secondary hospitals), and
- strengthening the capacity of these referral facilities to resolve life-threatening pregnancy, delivery, and post-partum/post-abortion complications.

Presently, most PHC facilities in USAID-assisted states do not have skilled birth attendants. While future efforts will include developing and supporting this capability, at present the appropriate approach to increasing institutional delivery for even routine deliveries is to channel that demand to referral level facilities (and strengthen their capability). Immediate and sustained efforts also need to focus on getting complicated pregnancies and births to these secondary facilities, including recognition by couples and community workers of the danger signs and complications of pregnancy and child birth that require facility-based care, planning how that care will be accessed, and establishing a system to transport women to the appropriate facility. This approach could have a major impact on maternal mortality in the near term.

At the same time, analysis of numbers of births and the capacity of hospital facilities in an area where USAID is working in Kano indicates that these facilities, when operating at capacity, could handle only about 20 per cent of all births in their catchment areas. Therefore, in the long term, it is probably not feasible or advisable to promote births by all women in these referral facilities. Thus, beginning immediately, there should be a concurrent focus on building alternative sources of adequate care for routine deliveries, either through strengthened and staffed PHC facilities, increased training of lower level community health workers (e.g., female junior CHEWs) who can attend uncomplicated births and detect complications, or contracting out of midwifery services to trained midwives.

Finally, there are specific technologies whose introduction at appropriate levels could produce significant impact in reducing maternal mortality: the three most important are the use of either oxytocin (potentially in UniJect) or misoprostol to prevent and control post-partum hemorrhage, the use of magnesium sulfate to treat eclampsia and use of the Anti Shock Garment.

Routine Immunization: The USAID health strategy and immunization teams agree that the "Immunization Plus Days"- which are intended to strengthen polio eradication activities and to effectively deliver other interventions – appear to be failing at both. Based on these conclusions, and related recommendations, USAID/Nigeria will designate separate investments to support the extraordinary efforts of the polio eradication and accelerated measles control campaigns. In its core package, the focus should be on strengthening routine immunization, building on the highly regarded work underway in Bauchi and Sokoto. USAID will also deepen support to the ongoing wild polio virus eradication efforts, as Nigeria remains the epi-center of polio transmission globally. USAID will closely coordinate advocacy and oversight activities with the USAID Worldwide Polio Coordinator as well as CDC home office and detailed country personnel. In addition to polio resources being incorporated into USAID's state-level

program support mechanisms, to allow these state level activities to develop "win-win" relationships with polio eradication and accelerated measles activities, targeted support to high-risk states will be provided . Some resources will also be provided to support polio eradication campaign activities through WHO. While the two focus states will receive full RI support, USAID will also continue limited support to RI in Sokoto.

Immunization is an essential function of a working primary health care system, including the upstream management, logistics, and monitoring required to implement it. USAID has had some success in strengthening the ability to plan, implement, and monitor routine immunization at state, local, PHC and community levels. USAID should work to synthesize this experience, and collaborate with DfID and the European Union (EU) in combining our experience with that of the Partnership for Reviving Routine Immunization in Northern Nigeria (PRRINN) and Partnership to Reinforce Immunization Efficiency (PRIME) projects, to develop a coherent approach and program materials that can be used to support states and local governments in strengthening routine immunization.

In line with the findings of USAID's immunization assessment team, the key foci of work in supporting routine immunization as part of PHC should include strengthening facilities and building structural and human capacity to:

- ensure vaccine and vaccination supplies at service delivery points;
- increase the number of service delivery points reliably providing immunizations;
- increase and sustain high levels of attendance during immunization sessions; and,
- strengthen monitoring and ,data management and use at LGA and health facility levels.

The importance of child immunization should also be a major component of BCC messages through a range of channels including outreach and mass media. Community health committees should raise awareness of the importance of immunization, and antenatal visits should be used as an opportunity to identify children in need and counsel the mother on the importance of fully immunizing the next child. Community organization can be used also to organize the population for routine outreach (which is a key component of routine immunization in settings with low facility coverage) and also for extraordinary campaigns, as are implemented for polio and measles.

Overall, to achieve these results, USAID will support full adoption of reaching every ward (REW) strategy, to include:

- decentralized ownership of routine immunization at state and LGA levels;
- increased and sustained immunization coverage through community planning;
- strengthened health worker, facility, and government capacity; and,
- through these inputs, development of a functional and affordable approach to improving routine immunization services as a core component of primary health care.
- Institutionalization of supportive supervision at LGA and facility levels.

Childhood Nutrition Interventions including Vitamin A: Program efforts should focus on maximizing coverage of exclusive breast-feeding and Vitamin A through multiple channels, with emphasis on increasingly doing this through primary services and community mobilization. Routine outreach services is a core function of PHC and should be used to the maximum to achieve high levels of vitamin A coverage. Delivery at PHC and other facilities should also be strengthened – this will require knowing children's vitamin A capsule administration status (as well as their immunization status), making the use of immunization and child health cards retained by mothers an important element. Community identification of children needing vitamin A and immunization can contribute to increased coverage, as can focused community-organized "child health days." With vitamin A supplies and delivery strategies being driven by other partners, it will be necessary for USAID-supported PHC strengthening activities to

help maximize the effect of these investments through improved planning and organization; however, the emphasis should be on increasingly delivering vitamin A through less intensive, and disruptive, approaches than IPDs.

"Malaria+," including treatment of child illness: About 110 million cases of malaria are diagnosed each year in Nigeria, accounting for more than 60 percent of outpatient visits and 30 percent of hospitalizations. Malaria is the leading cause of mortality in children under five, killing an estimated 300,000 children a year. USAID and other partners (World Bank "Malaria Booster" program, Global Fund) are making substantial investment in improving the availability and use of effective treatment (Artemisinin-based Combination Therapy) through public sector and private channels. These investments can act as the leading edge of a package of appropriate care-seeking and treatment of malaria, diarrhea (with ORT), and pneumonia – thus addressing the other two leading causes of post-neonatal infant and child death - again in both public and private services.

For malaria, the package will also include provision and promotion of use of insecticide-treated bed nets (ITNs). Again, this will be carried out through all potentially effective public and private sector channels. At community level, there are important opportunities for BCC and organization around obtaining ITNs and their use by pregnant women and children under five.

Who will deliver the interventions? All of the interventions listed above, with the exception of resolving major complications of pregnancy and delivery, can be delivered at the community level by a range of community-based and facility-based public and private sector workers with relatively low levels of training. These include CHEWS, auxiliary nurse-midwives, trained community volunteers, patent medicine vendors, pharmacists, etc. The real key is availability of the information and services as close to the community as possible, and commitment of the community - through Community Coalitions and other similar social action groups - to support, advocate for, and promote utilization of such services. Both the public and the private sectors can be important players in the effort to enhance demand and improve supply of services. While free, high quality, reliable public sector services for the poor is an important objective, there are a range of private sector options (discussed below) that can make services broadly available rapidly. This selective package of MCH/FP/RH interventions, and its intention to strengthen primary health care services and to engage the private sector, is consistent with GON and state policies and with "Standing Orders" for relevant categories of health workers. It is also consistent with the government's IMNCH strategy, although this core package is more focused. Such a focused package is consistent with the "phased" approach to system strengthening and capacity building supported by state level informants and donor partners and by the actual program experience of USAID's own implementing partners.

What larger "system support functions" are required? There are many components of an effective program, all of which need to be working well in order to have a functional system; but whatever the intervention, and whatever the service delivery point, without the necessary supplies and commodities, there is no program. **Logistics** is major issue that can undermine the best efforts and requires priority attention on the central, state, LGA and community levels. Secondly, without **staff** at the PHC/community level there will be little progress. There may also be operational **policy** constraints that preclude bringing services to people in communities and that need to be addressed at the outset. Such issues as who can provide certain drugs or give injections, the staffing and equipping of PHC facilities and the payment of salaries for those staff, and the appropriate role of the private sector need to be clarified in order to assure implementation of an effective program that reaches the population. These are issues that need to be addressed in collaboration with other donors and the GON at the State and LGA levels. USAID will also seek to coordinate support to help leverage the bonded conditional grants to states from the Office of the Senior Special Assistant to the President on Millennium Development Goals (MDGs).

4. Concentrate investment and effort in two major areas:

a. Making public sector primary health care work within the two focus states -

A relevant role for USAID in Nigeria's MCH/FP/RH development will require engagement with service delivery by the public health "system" and utilization of those services by the target population. The focus should be on strengthening delivery of services and information at the primary and community levels, with engagement at the secondary level where essential for vital interventions (specifically, emergency obstetric care).

Realistically, there are so many deficits at so many levels of this system, such engagement must be looked upon as – at best – an investment that will only deliver public health improvement at scale in the medium term.

As illustrated in Figure 1 (attached), there are important roles for inputs by donors – including, but not limited to, USAID - in strengthening primary health care at all levels of the public health system, including:

- Federal level (MoH, NPHCDA, MoF, MDG Fund, Legislature); tertiary (teaching hospital) services
- State level (MoH and other health-related entities like Health Services Management, budget and finance managers, SPHCDA [where instituted], Ministry of Local Government., Governors and assemblies); secondary hospital and clinical services
- Local Government level (LGAs); primary and community services
- Communities.

During 2009-2016 USAID should focus the majority of its public sector investments and effort at the state level and below in the selected focus states. Among potential activities at these levels, in general order of priority, are:

Community and primary services level: As noted above, USAID in Nigeria already has substantial experience and investment in engaging in the community level and in strengthening primary and – to a lesser degree – secondary level services; USAID will extend and synthesize this experience and work with other partners to scale it up within the larger system.

LGA level: While there have been some successes in establishing community organization and demand and in strengthening primary services, the LGA level remains a critical "missing link" in making the health system function. The fragmentation of responsibility at this level (personnel managed by the Ministry of Local Government., resources by the LGA) and especially the lack of capacity and a defined structured approach to priority setting, resource allocation, and health services management at this level, make the LGA level perhaps the greatest obstacle to effective health service delivery.

As an important part of its public sector work during the next five years, USAID will partner with state and local authorities and other donors and stakeholders to systematically analyze, improve, and evaluate LGA support for health services, again aiming for at-scale approaches. Inputs might include building technical and management capacity of relevant LGA authorities (particularly technocrats who will outlast political cycles); developing and institutionalizing tools for planning, resource allocation, monitoring, and quality improvement; establishing partnerships with communities for advocacy, co-management, and monitoring of primary health services; and strengthening of key system elements such as "last mile" logistics and supply management. (These purely public side inputs at local government level may be

complemented by public private approaches such as contracting for service delivery or for non-clinical services such as IEC or supply delivery – see b., below.)

In states taking a higher level structured approach to improving LGA functionality in health services (such as instituting a state level PHCDA, with or without budget and personnel management authority), USAID and partners will likely want to provide management and technical support to that approach. It may also be critically important to subject that approach to expert management and financing analyses, areas where USAID has strong technical expertise.

State level: At state level, it is likely that other donor partners may be better positioned to lead on the political issues of health-specific legislation, fiscal policy, budgeting, resource allocation, transparency, and accountability. However, USAID may selectively engage in these areas, especially to assure that the needs and successful approaches identified through its engagement in the system are adequately represented. USAID will also may strategically provide some portion of its direct inputs at the state level, especially focusing on capacity building and quality of relevant clinical services (such as maternity services), technical policies (such as use of injectable contraceptives by categories of health workers), strengthening key systems (e.g., procurement, logistics management, monitoring), and training of important cadres such as CHEWS and nurse-midwives.

It will also be important for USAID to be strongly engaged in overarching government-partner activities at this level in its focus states, such as strategic planning, periodic sector reviews, development of MDG Fund and other proposals, and donor coordination. In this process, feedback from existing implementing partners indicates that a strong presence by responsible and experienced USAID decision-makers (rather than individual IP representatives) will achieve greater effectiveness and leverage of USAID's inputs. (Resident state-level USAID representation, as is being discussed, would clearly enhance this influence and leverage of USAID's investments.)

Federal level: In spite of this strong focus on the state, local government, service delivery, and community levels, USAID will also engage in a limited and strategic way at the federal level. At this level, other donors are again better positioned to interact with the political and macro-level issues of legislation, resource allocation and disbursement, transparency, regulation, and structural/institutional policy. However, in such areas, USAID and the embassy will assure that USG interests and approaches are represented through participation in relevant fora, including donor coordination processes and donor-government bodies such as the Interagency Coordinating Committee (ICC) and Country Coordination Mechanism (CCM). USAID will continue an active role in activities such as development of national Global Alliance for Vaccines and Immunization (GAVI) and Global Fund for AIDS, Tuberculosis and Malaria (GFATM) proposals. USAID representatives and representatives of USAID implementing partners will participate as appropriate in such areas as technical policy development and technical reviews. As at state level, USAID may selectively help develop and support fora and mechanisms for review and synthesis of program experience and identification of key program and policy issues requiring increased attention from government and partners.

In addition, in consultation with government and partners, USAID may identify a highly important technical or policy area where it is uniquely positioned to offer short or long-term assistance at national level that will contribute significantly to health service delivery. One example might be further development and implementation of the National Health Insurance System.

As noted, to maximize its inputs and leverage, at all levels where it is engaged, USAID will work with government and partners in developing mechanisms to identify, synthesize, disseminate, and replicate successful approaches.

b. Identifying and developing high impact, scalable and sustainable Public Private Partnerships -

There is no reason why a country with the economic and entrepreneurial dynamism of Nigeria should have almost two of every ten children die before the age of five, nor a maternal mortality ratio above 1000/100,000. The recently approved "National Policy on Public Private Partnership for Health in Nigeria" provides a framework for systematically engaging the private sector in improving public health outcomes. This policy is comprehensive, laying out potential roles for a broad range of private sector approaches (from service provision by NGOs in underserved areas, to social marketing, to contracting non-clinical functions, to actual for-profit delivery of services) as well as the corresponding roles of government (e.g., providing grants to NGOs, developing and managing contracts, strengthening regulatory functions, and providing tax and other incentives). It includes a realistic and frank problem assessment (e.g., the public sector's lack of human resources combined with underutilization and weak capacity and performance of their existing human resources) and at the same time lays out a visionary approach that, if realized, could substantially contribute to improved health of Nigerians.

Operationalizing this policy could yield relatively rapid results (compared to strengthening public sector services), because the private sector is already the largest provider of health services and because Nigeria has substantial existing private sector management, technical, entrepreneurial, delivery capacity, and capital to draw upon.

However, at present this policy essentially exists only on paper. Government officials and donor partners at both federal and state levels welcomed the prospect of implementing such public private partnerships for health. USAID is unique among donors in having at-scale program experience and technical expertise in working with the private sector, along with a development approach and high level mandate that strongly support such private sector involvement in the interest of improved national outcomes.

It is recommended that USAID support two categories of public private partnership under the 2009-2016 strategy; overall, a substantial portion of USAID's MCH/FP/RH resources (up to one-half, as required for successful at-scale programming) should be dedicated to these public private partnership approaches:

1. *Expanded social marketing, building on the existing successful RH/FP social marketing program.*

   USAID's present program in FP/RH social marketing - which is a collaborative activity cost-shared with DfID - and malaria social marketing has achieved significant results in increasing accessibility and use of key interventions. The next program cycle should build on this success, expanding coverage and also expanding the package of commodities promoted to cover a larger portion of the core MCH/FP/RH interventions. Thus, in addition to multiple contraceptive methods, Artemisinin-based combination therapy (ACT) treatment for malaria, and ITNs, the social marketing program should include ORS, prenatal iron (which has been demonstrated to yield a 10 per cent reduction in maternal mortality in areas like Nigeria where maternal anemia is highly prevalent and often severe), and possibly point-of-use (POU) water treatment and soap for hand washing. In addition, for those private practitioners who are authorized to do so (especially if policy evolves to allow expanded authority to lower level health workers), the package may include expanded use of injectable contraceptives and of antibiotic treatment for child pneumonia.

   The social marketing program is presently operating in multiple states; this should be continued, and even expanded. However, the program should also be directed to have a strong focus on the two "focus states," seeking to achieve greatest possible saturation of key MCH/FP/RH interventions in those two states.

2. *Identification, development, and scaling up of at least one additional public private partnership that will substantively contribute to one or more elements of the MCH/FP/RH package*.

   USAID has substantial experience in developing and implementing non-subsidized partnerships with the private sector, in the context of public sector regulation or management and with the aim of achieving public health improvement. This experience includes, for example:

   – at-scale delivery of basic health services by private sector organizations through contracting and oversight by government, as in Afghanistan and Cambodia;
   – engagement in development and implementation of successful health insurance programs in countries (including Ghana, Senegal and Rwanda in Africa, as well as Cambodia, India, Bolivia, and others);
   – development of performance-based financing and other incentive approaches in Rwanda and other countries;
   – use of Development Credit Authority to increase access to capital for activities such as water and sanitation, as in India.

   USAID/Nigeria's 2009-2016 health strategy will respond to the important opportunity provided by the Public Private Partnership for Health Strategy to develop additional impact-oriented at-scale public private partnerships. Some opportunities – such as strengthening and systematizing the role of licensed patent medicine vendors in promoting and delivering key services - stand out as having substantial potential for rapidly reaching large population segments. However, the first step needs to be a process of further analysis and consultation, building upon the excellent assessments recently done by PSP-*One*. This process should identify one or two PPP approaches that will be accepted and can feasibly implemented by the relevant public and private parties. USAID resources should then be used to take the approach(es) to a level of development that will allow replication, expansion, and sustained activity through other public, private, and/or donor resources.

   As with social marketing, this new public private partnership activity may include more than the two "focus states;" again, however, the program should be directed to have a strong focus on the "focus states," seeking to achieve greatest possible saturation of key MCH/FP/RH interventions in those two states.

5. <u>Build in systematic program-based learning and analysis, and use these to inform at-scale program and policy</u>

Among USAID's greatest comparative advantages are its ability to apply technical and development expertise at the delivery end of health systems, and in doing so, to learn what needs to be done to make those systems deliver health results. In Nigeria, this engagement has produced demonstration of the feasibility and effectiveness of community mobilization in increasing utilization of key health services, and of the inputs required to improve functionality of some essential primary MCH/FP services. However, this strength also becomes a weakness when – as in Nigeria – the approaches of individual implementing partners differ from each other, reach only a very small part of the overall population, are not part of an accepted government-led multi-partner programming approach, and when there is no mechanism for injecting this experience into the broader stream of program investment. (End-of-project "lessons learned" activities are generally very ineffective in influencing future program investment by host governments and other donors.)

The lessons learned through USAID's program support investments in Nigeria are acknowledged by some important stakeholders – especially public sector partners) as potentially important in increasing functionality of health services (other stakeholders, however, including some important donor partners, are relatively uninformed about USAID's activities and experiences).

Therefore, to achieve greatest leverage from USAID's approach, all of its next generation of MCH/FP/RH activities should specifically include a real-time "learning and uplink" function as a core component. For each major implementing mechanism in the 2009-2016 program, this "learning and uplink" function will involve:

- providing strong capacity in operations and evaluation research aimed at extracting credible evidence from program experience;
- applying this capacity within a strategic framework aimed at developing program, management, and behavioral approaches that address key constraints to improved health and fertility outcomes (where possible, this framework should be developed with stakeholders including relevant levels of government);
- engaging in and supporting appropriate fora and mechanisms, developed with decision-makers and stakeholders, that allow for the introduction of evidence and experience from both USAID-supported and other relevant programming into policy, program, and resource allocation; and,
- both USAID and senior implementing partner activity managers actively engaging in this process of connecting program-based learning and analysis with decision-making at relevant levels.

6. Achieve greater integration and synergy of MCH/FP/RH assistance with other USAID/Nigeria assistance activities

There are a number of other areas of USAID assistance where MCH/FP/RH investment can complement, and be complemented by, other health and non-health investments, in ways that deliver "win-win" outcomes. Most prominent among these are:

a. *FP/MCH/HIV Integration*: There is a need to strengthen the linkages between FP/MNCH and HIV/PEPFAR programming within USAID and in collaboration with other donors and the Government. As a start, the offices within the Mission should review current strategies to address this crucial integration issue. Efforts should be made to reinvigorate the communication/collaboration between PEPFAR/USAID-supported projects and the FP/MCH program, particularly in those states where both programs are currently being implemented. These discussions and the findings of the current GHAIN evaluation should provide guidance on opportunities for integration of activities in the future.

Examples of opportunities not to be missed include PMTCT linked to ANC+; use of primary and community services and organization (as they develop) to participate in follow-up and treatment of HIV-exposed and infected children and HIV+ mothers; integrated messages delivered by a range of communication channels; and capitalizing on antenatal and primary care visits to address relevant HIV, RH and MCH issues. PEPFAR's investments in immunization safety can be linked to USAID's investments in strengthening immunization services in PHC. On the secondary hospital level, PEPFAR can strengthen PMTCT platforms which can then improve the quality of other family planning, post-partum family planning, and MCH services, especially ANC, delivery, and post-partum/newborn services.

Reportedly, PEPFAR-supported prevention, care, and treatment activities are beginning to move from the hospital level to the local, PHC, and community levels in at least some states. Since there is presently limited capacity - and much opportunity for strengthening capacity, service delivery, and

communication - at these levels, it is likely that there will be significant opportunities for "win-win" wrap-around and integrated MCH/FP/RH and HIV/AIDS investments. These should be proactively defined and pursued.

In addition, PEPFAR has developed an effective logistics system which is parallel to other logistics systems. The potential for leveraging that system should be explored.

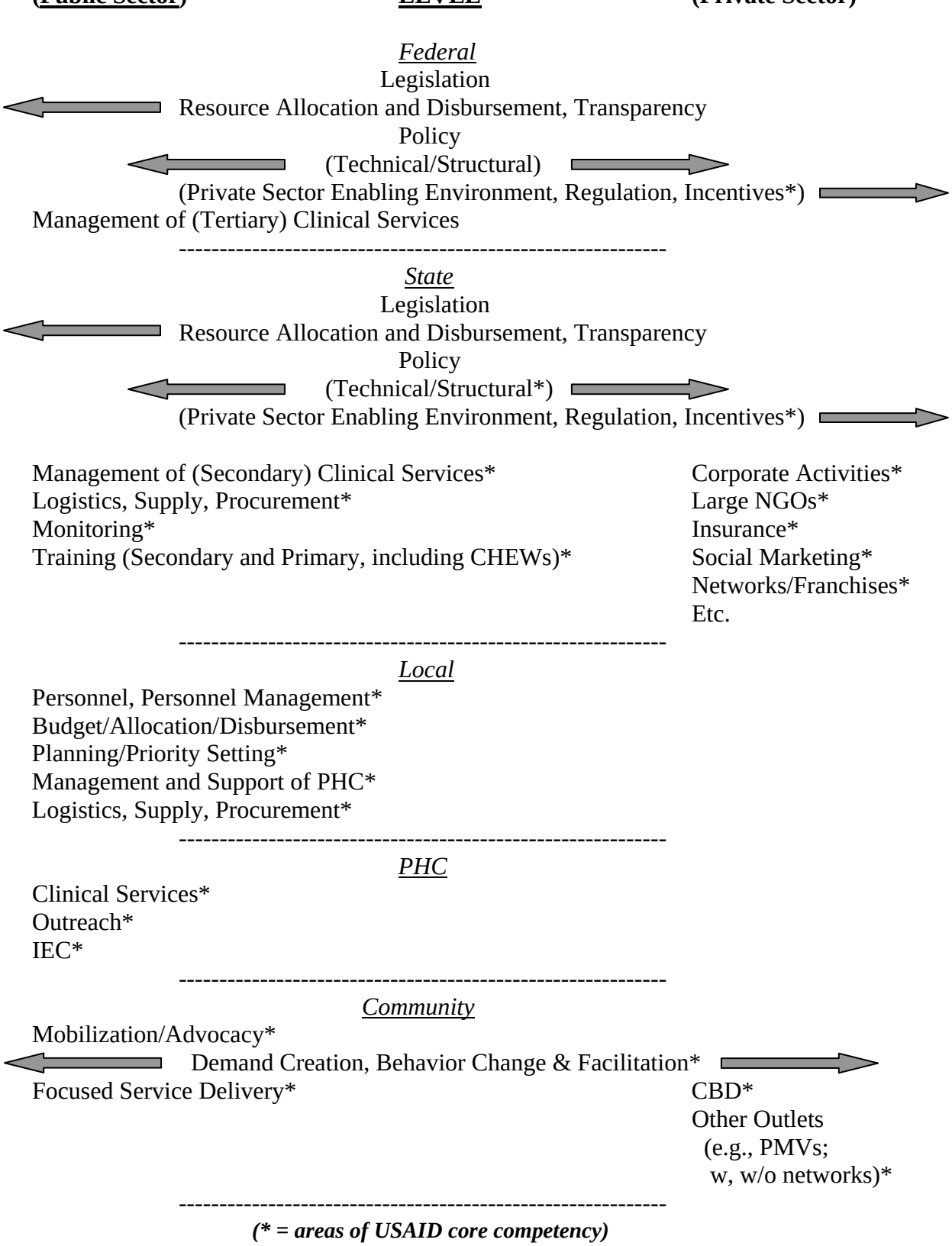
b. Water and Sanitation: The Mission is currently planning to allocate 2 million dollars in water and sanitation funds in approximately equal shares to: local governance activities; municipal water systems; and to actual hardware investments (e.g., bore holes) in communities. To the greatest extent possible, it will be important to co-locate these activities in health focus states, and to seek maximum benefit to community health through joint planning of these activities. For example, water installation might be focused on Primary Health Care facilities as part of efforts to increase functionality of those facilities. Community organizations assisted by either MCH/FP/RH or governance activities might be given the capability to support maintenance and repair ("software components") of water facilities, to complement installations by either USAID or DoD. In addition, through PEPFAR the Mission already supports point-of-use water treatment, focused on HIV-affected families and communities – these activities might be expanded to other households through MCH/FP/RH social marketing of water purification products. Again, congruence with health focus states would create opportunities for joint planning and mutually supportive implementation.

c. Governance: In addition to focusing USAID's own health inputs under a coherent programmatic (versus a fragmented project-by-project) approach, the strategy team sees additional potential impact by applying USAID's governance expertise alongside its health investments. In many respects, USAID's MCH/FP/RH health programming already includes strong governance elements, especially through community organization and "empowerment" (development of self-responsibility for health outcomes) and through communities' representation of their own interests and demands with local government. However, substantial value could be added to USAID's direct health activities by bringing governance expertise to some of the key challenges faced in improving health services. Two areas where this could be especially beneficial are:

- strengthening the now ill-defined function and accountability of Local Government authorities in supporting, managing, and financing primary health care services (as well as education), and
- implementation of public private partnerships.

While many of the current health activities involve a governance component in the sense that they work with communities to empower them to make improvements on their own and to advocate for resources from LGA and state level government, there is a great deal more that could be done to create partnerships between state governments, LGAs and civil society for the betterment of health systems.

Figure 1 – Opportunities for USAID/Partner Inputs at Levels of the Health System



Recommended Mechanisms

Figure 2 – Proposed structure of USAID/Nigeria MCH/FP/RH Assistance (Mechanisms)